

EXHIBIT C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

MUTINTA MICHELO, <i>et al.</i> ,)	
)	
Plaintiffs,)	
v.)	
)	18 Civ. 1781 (PGG)
NATIONAL COLLEGIATE STUDENT)	18 Civ. 7692 (PGG)
LOAN TRUST 2007-2, <i>et al.</i> ,)	
)	
Defendants.)	
_____)	

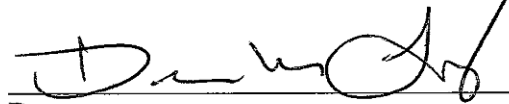
DECLARATION

I, Dennis Lacey hereby declare and state:

1. I am over the age of 18 and competent to testify to the matters stated herein.
2. I am duly authorized to make the representations contained in this Declaration and am competent to testify to the matters stated in this Declaration.
3. The medical records attached hereto were created, compiled and recorded as part of regularly conducted business activity at or near the time of the event and from information transmitted from a person with personal knowledge of said event and a business duty to report it, or from information transmitted by a person with personal knowledge of the events described within the business record. Such records are created, kept, maintained, and relied upon in the course of ordinary and regularly conducted business activity.

I declare under penalty of perjury under the laws of the United States of America and all other applicable laws in the present proceedings that the following is true and correct.

Executed on March 29, 2021.


By: _____
Title: _____

Drs. Lacey & Freschi, P. C.

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SLEEP MEDICINE
NERVE CONDUCTION STUDIES
ELECTROMYOGRAPHY (EMG)
ELECTROENCEPHALOGRAPHY
(EEG)


December 28, 2020

RETURN OFFICE VISIT

PATIENT: [REDACTED]

[REDACTED] returns post-stroke syndrome. [REDACTED] continues making excellent progress, with his speech being 80-90% back to normal. There is no difficulty with chewing or swallowing. Appetite is good. Sleep is generally good, although [REDACTED] does have occasional dark thoughts with fear of death. [REDACTED] is able to eventually fall asleep.

[REDACTED] is doing some exercise but not as vigorously as I would like, so again I have encouraged him to step that up. [REDACTED] just retired, so I also encouraged him to start thinking about what his next plan is, and to not fall into the trap of being overly sedentary and non-stimulated. I will see [REDACTED] back in several months.


Michael Lacey, M.D.
ML:fs

Drs. Lacey & Freschi, P. C.

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SLEEP MEDICINE
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(EEG)

October 16, 2020

RETURN OFFICE VISIT

PATIENT: [REDACTED]

[REDACTED] returns for recheck of his stroke. [REDACTED] continues making excellent progress, with his gait more stable, speech more fluent, content still is appropriate. Appetite and sleep are decent (though [REDACTED] has anxiety causing occasional insomnia, like many people in the last six months).

Therefore, I am going to continue [REDACTED] physical therapy, 81 mg aspirin a day and again encouraging [REDACTED] to stay physically and cognitively active and will see [REDACTED] in two months.


Michael Lacey, M.D.
ML:fs



Initial Evaluation

Sovereign Rehabilitation of Georgia
Conyers
1301 Sigman Road
Suite 220
Conyers, GA 30012
tel: 678-210-0311
fax: 678-210-0335

Patient: [REDACTED] (MRN # 1005010928)
Gender: [REDACTED]
DOB: [REDACTED]

Visit #1: 09/25/2020
Evaluation Date: 09/25/2020
Injury Date: n/a

FAXED
9/25/20

Therapist of Record: Cassandra Wilhelm PT
Referring Practitioner: Michael Lacey MD

Onset Date: 08/03/2020
Provider: Cassandra Wilhelm PT
Provider Email: cassandra.wilhelm@sovereignrehab.com

#	Medical Diagnoses	ICD10	#	Treating Diagnoses	ICD10
1)	Cerebral infarction, unspecified	I63.9	1)	Cerebral infarction, unspecified	I63.9
2)	Unsteadiness on feet	R26.81	2)	Unsteadiness on feet	R26.81

Reason For Referral

Pt's wife remained in waiting room for duration of treatment session.

Pt presents to clinic with complaints of unsteadiness on feet subsequent to a CVA that occurred on 08/03/2020. Pt states [REDACTED] experienced a stroke on the R side of [REDACTED] brain while at work. Pt reports [REDACTED] "got confused, couldn't feel [REDACTED] speaking and [REDACTED] mouth felt like it was stuck to the side. Pt states [REDACTED] wife took to the hospital and [REDACTED] received an MRI that confirmed a stroke.

Pt denies any dizziness, inc in headaches, changes in vision. Pt reports [REDACTED] sensation and strength seemed to return to normal with the exception of a tingling sensation in B hands that occasionally radiates up the arms.

Pt denies any history of falls since. However, states [REDACTED] doesn't walk with "same confidence" [REDACTED] had before and grabs for objects to steady [REDACTED] when walking. Pt states [REDACTED] must use the handrail to navigate the stairs within [REDACTED] home when [REDACTED] previously didn't have to.

Previous interventions for current condition: none

Occupation/hobbies: office work, has not returned since the accident - must be cleared by MD to go back; yardwork

Chief complaint: unsteadiness on feet

- Current: 0/10
- Worst: 0/10

Aggravating factors: walking incline>decline (driveway); standing bending to pick object off the ground; decreased endurance walking/standing > 30 min

Ease factors: rest

PLOF: otherwise independent with ADLs and driving

Pt goals: improve the way [REDACTED] walks

Numeric Pain Rating: 0

Medical History

Prior & Existing Conditions: Allergies, High/Low Blood Pressure, Seizures, Smoking, Speech Problems, Strokes

Additional Information: See scanned documents for past surgical history and list of current medications.

PMH:

- Stroke: 08/03/2020

Fall History: Patient has **not** been injured by a fall in the past year. Patient has **not** had two or more falls in the past year. Patient is **not** at risk for falls.

Medications:

Medications scanned into patient's file.

Measures

The following measures were identified for the patient's **Neurological** condition:

Measure	Current (09/25/2020)	Target
Activities-specific Balance Confidence (ABC) Scale Score on the Activities-specific Balance Confidence (ABC) Scale	62%	Complete confidence in balance; ABC Scale score > 95
Dynamic Gait Index (DGI) Score on the Dynamic Gait Index (DGI)	19	Normal gait; DGI score of 24
Timed Up-and-Go Test (TUG) Time to rise from chair, walk 3 meters, turn, walk back and sit down	10 sec	Negligible fall risk: Time to complete 3mTUG < 12 seconds
Five Times Sit-to-stand Test Score on the Five Times Sit-to-stand test; 14 seconds or greater indicates FALL RISK	19 sec	Normal: Able to complete test in less than 12 seconds
Dizziness Handicap Inventory Scale (DHIS) Score on the Dizziness Handicap Inventory Scale (DHIS)	14%	No dizziness: DHIS score 0 to 4
Pain (at rest) Current level of pain	No pain: 0/10	No pain: 0/10
Pain (at worst) Highest level of pain during the last 24 hours	No pain: 0/10	No pain: 0/10
AROM (lumbar left sidebending) Lumbar left sidebending active range of motion	No impairment: > 25° of sidebending	No impairment: > 25° of sidebending
AROM (lumbar right sidebending) Lumbar right sidebending active range of motion	No impairment: > 25° of sidebending	No impairment: > 25° of sidebending
AROM (lumbar extension) Lumbar extension active range of motion	No impairment: > 25° of extension	No impairment: > 25° of extension
AROM (lumbar flexion) Lumbar flexion active range of motion	No impairment: > 50° of flexion	No impairment: > 50° of flexion
AROM (thoraco-lumbar left rotation) Lumbar left rotation active range of motion	No impairment: > 40° of rotation	No impairment: > 40° of rotation
AROM (thoraco-lumbar right rotation) Lumbar right rotation active range of motion	No impairment: > 40° of rotation	No impairment: > 40° of rotation
AROM (cervical flexion) Cervical flexion active range of motion	No impairment: > 55° of flexion	No impairment: > 55° of flexion
AROM (cervical extension) Cervical extension active range of motion	No impairment: > 65° of extension	No impairment: > 65° of extension
AROM (cervical rotation) Cervical rotation active range of motion	Mild impairment: (60 to 74) degrees of rotation	No impairment: Rotation of 75 degrees or more
AROM (cervical sidebending) Cervical sidebending active range of motion	No impairment: Sidebending of 45 degrees or more	No impairment: Sidebending of 45 degrees or more
Strength (hip extensors) Gluteus maximus muscle test grade	L 3/5, R 4-5	Normal: 5/5 strength
Strength (hip abductors tensor fascia lata) Tensor Fascia Lata muscle test grade	5/5 B	Normal: 5/5 strength
Strength (hip flexion) Psoas / iliacus muscle test grade	4/5 B	Normal: 5/5 strength
Strength (knee extension / quadriceps) Quadriceps femoris with manual muscle testing	5/5 B	Normal: 5/5 strength
Strength (knee flexion) Hamstring / gastrocnemius with manual muscle testing	R 5/5, L 4/5	Normal: 5/5 strength
Strength (ankle dorsiflexion) Tibialis anterior manual muscle testing	5/5 B	Normal: 5/5 strength
Strength (heel raise strength) Repetitions of single-leg heel raise	R 30 reps, L 32 reps	Normal: > 24 repetitions
6 Minute Walk Test (6MWT) Distance walked in 6 minutes on level surface or 0 % incline on a treadmill	Average aerobic fitness - able to walk 1316 feet	Good aerobic fitness - able to walk (0.25 to 0.34) miles (1320 to 1847 feet)

Additional Evaluative Findings

Observation:

- No signs of antalgic gait or clinically significant gait deviations from straight path ambulating throughout clinic

- Oculomotor motility: WNL B

Palpation: N/A

Special tests:

- Smooth pursuit: horizontal positive for saccadic lag to R; no saccadic lag noted with vertical but subj reports of "exhaustion" following
- Saccades: difficulty tracking both horizontal and vertical; subj c/o dizziness

Balance:

- Modified CTSIB
- > Rhomberg EO: no sway
- > Rhomberg EC: minimal sway - c/o dizziness following
- > Rhomberg foam EO: mild sway
- > Rhomberg foam EC: mild sway - c/o dizziness following
- R SLS: 6 sec, 30 sec
- L SLS: 30 sec
- Tandem EO: 30 sec each LE leading

Assessment

The examination of [REDACTED] identified coordination impairments, weakness and unsteadiness on feet associated with a stroke. Intervention strategies designed to address these impairments will be instrumental in achieving the stated functional goals, including [REDACTED] ability to perform mobility tasks independently. Based on the examination, the patient's rehabilitation potential to achieve functional goals is good.

Plan

Check tolerance and performance of home exercise program.

Add glut strengthening as tolerable.

Plan of Care: Neurological

Functional Goals:

1. Pt will demonstrate 2 or more point increase in DGI functional outcome measure indicating decreased risk for falls; Time frame: 8 weeks.
2. Pt will report 50% reduction in overall dizziness symptoms while ambulating with head turns so that [REDACTED] can safely navigate the community with decreased fear of falling; Time frame: 8 weeks.
3. Pt will report >25% improvement in overall confidence in ambulation according to the ABC functional outcome measure for improved overall QOL; Time frame: 8 week.

Intervention Strategy

Neurological

Therapeutic Activities education, instruction and performance cues to utilize movement options with optimal base of support, segmental alignment and sequencing while performing dynamic functional activities.

Therapeutic Exercise exercise incorporating verbal, manual and proprioceptive performance cues and instruction to restore optimal movement coordination by improving the strength, endurance and motor control of weak trunk muscles and improving the flexibility of tight muscles to improve the ability of the patient to perform functional activities.

Neuromuscular Reeducation techniques incorporating verbal, manual and proprioceptive performance cues and instruction to reeducate movement patterns, improve coordination, normalize alignment and integrate proprioceptive and motor control gains with the ability to safely and efficiently perform functional movement patterns and activities.

Gait Training to improve the motor control, flexibility, strength, endurance and integrated coordination associated with normal ambulation.

Manual Therapy soft tissue mobilization, joint mobilization and manual stretching procedures to improve the mobility of the involved shortened, inflexible tissue to restore alignment and mobility.

Unlisted Procedure Dry needling to associated musculature.

Electrical Stimulation (Manual -97032) to facilitate contraction, motor control and strength of the involved musculature while performing functional activities.

Recommendations

[REDACTED] will be seen for therapy as described at the following frequency and duration: 2 visits per week for 8 weeks (however, pt initially attending 1x/week due to high co-pay).

Per payer requirements, please sign this Initial Evaluation Report form, certifying this physical therapy plan of care and return the form to our office. Thank you.

The patient was actively involved in the development of the Therapy Plan of Care and understands it and is in agreement with it.

Treatment Provided Today

The following interventions were performed for the patient's neurological condition:

PT Eval Low Complexity (97161): 15 min

Therapeutic Activities (97530): 10 min

Pt education:

- On the current condition, prognosis and expected functional outcomes based on evaluative findings.
- On movements and activities to avoid to limit the exacerbation of the patient's current condition.
- On importance of energy conservation to decrease excess fatigue of the LEs.
- Initial HEP developed w/ handout.

Neuromuscular Reeducation (97112): 30 min

Performed the following to address unsteadiness on feet and S&S of vestibular dysfunction.

Seated horizontal saccades: 3x30 sec

Seated vertical saccades: 3x30 sec

Tandem stance w/ eyes open: 3x30 sec each LE leading

SLS with eyes open: 3x30 sec each B

Narrow stance with eyes closed: 4x30 sec

Walking w/ horizontal head turns: 4x20ft

Education materials were given to patient for the following home exercises

Notes

Initial HEP: (handout provided 9/25/20) Gastroc stretch at wall Seated saccades - horizontal and vertical Tandem stance w/ eyes open SLS with eyes open Narrow stance with eyes closed Walking w/ horizontal head turns

Provider Interactions With Patient During Visit

Education on the current condition, prognosis and expected functional outcomes based on evaluative findings.

Assessed ability to perform home exercise program safely and independently.

Treatment Time

40 minutes direct contact (timed) with patient.

55 minutes total treatment time.

Therapist Signature(s)

Electronically signed by Cassandra Wilhelm PT at 09/28/2020 07:57 AM EDT

Referral Signature

☒ I certify and concur with the outlined Plan of Care and that [REDACTED] remains under my care.

☐

Referral Signature: 

Date: 9/28/20

Print Name: Michael Lacey MD

Drs. Lacey & Freschi, P. C.

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SLEEP MEDICINE
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(EEG)

September 2, 2020

RETURN OFFICE VISIT

PATIENT: [REDACTED]

[REDACTED] comes into the office for evaluation of recent onset of slurred speech and left sided clumsiness. MRI scan has been done showing right thalamic infarct. [REDACTED] speech is better than when I last spoke to him two weeks ago but [REDACTED] is still having some issues with left sided function.


Therefore, physical exam was done which showed the following:

Cranial nerves are normal. Left facial features are slight flattening of the nasal labial fold. Tongue is midline and soft palate moves symmetrically. There is mild left pronator drift, though grip strength seems comparable. Lower extremity strength is symmetrical. Reflexes are symmetrical, as is pinprick sensation in left and right upper and lower extremities.

MRI is reviewed with [REDACTED] wife showing right thalamic ischemia. No significant stenosis or blockage is seen on MRA of the neck or head.

IMPRESSION:

Right thalamic stroke. Will therefore get [REDACTED] in physical therapy, continue 81 mg aspirin a day and then will see [REDACTED] back in six weeks to assess [REDACTED] progress.


Michael Lacey, M.D.
ML:fs

Drs. Lacey & Freschi, P. C.

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SLEEP MEDICINE
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ELECTROENCEPHALOGRAPHY
(EEG)

August 26, 2020

RETURN OFFICE VISIT

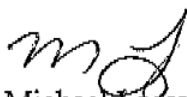
PATIENT: [REDACTED]

[REDACTED] returns via telemedicine appointment for recheck of [REDACTED] seizures. Seizures have been quite stable on carbamazepine. However, [REDACTED] had a spell a week or so ago where [REDACTED] states that [REDACTED] was at work and suddenly [REDACTED] had difficulty with [REDACTED] thinking, could not concentrate or clearly express [REDACTED] speech was slurred and [REDACTED] had numbness going down [REDACTED] left arm and felt like [REDACTED] left face was droopy. [REDACTED] states that this lasted a relatively short period of time and [REDACTED] went in for evaluation but no scans or other vascular diagnostic testing was done. [REDACTED] went to [REDACTED] primary care physician who has scheduled [REDACTED] for a CT scan of the brain.

[REDACTED] speech is much more deliberate and slow than is normal for [REDACTED], and [REDACTED] has a difficult time coming up with words on occasion. [REDACTED] is able to raise both hands and I can detect no obvious facial asymmetry. There is no difficulty chewing or swallowing and appetite has been decent. [REDACTED] moves all extremities and [REDACTED] walking is somewhat deliberate but non-ataxic.

IMPRESSION:

My concern is that [REDACTED] may have suffered a small stroke, so I am ordering an MRI of the brain and an MRA of the neck and head. I have instructed [REDACTED] to start taking an 81 mg aspirin per day and then will see [REDACTED] in the office in approximately two weeks (with [REDACTED] wife) in order to review results of the scan and determine any further disposition at that point in time based on how [REDACTED] is doing (such as physical therapy, speech therapy, etc.).


Michael Lacey, M.D.
ML:fs



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www.americanhealthimaging.com

Name: [REDACTED]
DOB: [REDACTED]
Gender: [REDACTED]

Exam Date: 8/31/2020 07:01 PM
Patient ID: AHI-1260281
Accession #: 2404533

Ordering Physician: Michael Lacey, MD
Exam Name: MRA Neck | 70547

MRA NECK

HISTORY: TIA

TECHNIQUE: Axial images of the neck using 2-D time-of-flight and 3-D time-of-flight technique were obtained.

FINDINGS:

Images of the carotid bifurcations were obtained using 2-D time-of-flight and 3-D time-of-flight technique. The aortic arch demonstrates no significant disease. The origins of the great vessels are widely patent.

The right common carotid artery courses normally to its terminus. The right ICA is widely patent. ECA is unremarkable.

The left common carotid artery courses normally to its terminus. The left ICA is widely patent. ECA is unremarkable. Note is made of an area of signal dropout involving the juncture of the horizontal and vertical petrous segment. On the accompanying circle of Willis MRA, this area is normal. Findings are felt to represent artifact.

The left vertebral is dominant. The vertebral arteries course normally to their confluence at the origin of the basilar artery. No stenosis is evident.

IMPRESSION:

Normal MRA of the circle of Willis.

Report Electronically Signed by: David Owens, M.D.
Report Electronically Signed on: 9/1/2020 08:37 AM

Radiology Report from an IAC Accredited Facility



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Fax #: (770)451-3003
www.americanhealthimaging.com



Gender: [Redacted]

Exam Date: 8/31/2020 07:27 PM

Patient ID: AHI-1260281

Accession #: 2404530

Ordering Physician: Michael Lacey, MD

Exam Name: MRI Brain | 70551

MRI BRAIN WITHOUT CONTRAST

HISTORY: CVA

TECHNIQUE: Multiplanar images of the brain were performed.

FINDINGS:

There is an ovoid area of abnormal increased signal on the FLAIR sequences within the body of the right caudate. This area measures 2.5 cm x 1.4 cm and demonstrates minimal localized mass effect. The area demonstrates increased signal on the diffusion sequences. The ADC map demonstrates mixed signal with both increased and slightly decreased characteristics which is suggestive of a subacute ischemic event which is most likely greater than ten days to two weeks of age. There is no hemorrhage evident.

Remainder of the study demonstrates the ventricles are normal in size. Very minimal subcortical punctate white matter hyperintensities are evident.

The brainstem is grossly normal. The basilar artery is widely patent. No CPA mass is identified.

The skull base and paranasal sinuses are unremarkable.

IMPRESSION:

Area of ischemia which involves the body of the right caudate. Patient has a history of TIA. The ADC map suggests that this lesion is at least ten days to two weeks in age if not older.

Report Electronically Signed by: David Owens, M.D.

Report Electronically Signed on: 9/1/2020 08:37 AM

Radiology Report from an IAC Accredited Facility



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Gender: [REDACTED]

Exam Date: 8/31/2020 07:08 PM

Patient ID: AHI-1260281

Accession #: 2404531

Ordering Physician: Michael Lacey, MD

Exam Name: MRA Brain | 70544

MRA CIRCLE OF WILLIS

HISTORY: CVA

TECHNIQUE: 3-D time-of-flight MRA images were acquired of the circle of Willis. MIP images were acquired.

FINDINGS:

3-D time-of-flight MRA images were acquired of the Circle of Willis.

The left vertebral artery is dominant. The basilar artery is widely patent. Posterior cerebral vessels fill normally. Posterior communicating arteries are patent bilaterally.

The ICA vessels course normally to their terminus. The left A1 segment of the ACA is aplastic. The right ACA is unremarkable. Middle cerebral vessels are grossly normal. There is no evidence of an anterior communicating artery aneurysm.

IMPRESSION:

Normal MRA of the circle of Willis.

Report Electronically Signed by: David Owens, M.D.

Report Electronically Signed on: 9/1/2020 08:38 AM

Radiology Report from an IAC Accredited Facility